CHAPTER 17

NEUROPSYCHIATRY DEPARTMENT

STANDARD OPERATING PROCEDURE

500 BED FLEET HOSPITAL

TABLE OF CONTENTS

500 BED COMBAT ZONE HOSPITAL

STANDARD OPERATING PROCEDURES

NEUROPSYCHIATRY DEPARTMENT

A. **MISSION:** Provide psychiatric services in support of combat related abnormalities.

B. **FUNCTIONS:**

1. Promote a healthy community milieu to provide an atmosphere where the combat casualty can expect the following to occur; comfort, caring, curing, change, acceptance, encouragement, healing, growth and vulnerability.

2. Evaluate psychiatric disorders in patients.

3. Provide secure environment to reduce stress.

4. Provide opportunities for ventilation of emotions, feelings and anxieties.

5. Maintain protective custody of patient to prevent injury to self and others.

6. Prepare patient for evacuation.

7. Consult with medical officers of other clinical services concerning psychiatric problems.

C. **PHYSICAL DESCRIPTION:**

1. The Head, Neuropsychiatry Department will use a desk on Ward Fourteen and float to other hospital areas.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tents

Quantity: One, fourteen section wing.

(c) Material.

IOL:

2. Ward Fourteen will be designated as the Neuropsychiatric ward with a minimum of fifteen beds reserved for Neuropsychiatric admissions.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tents

Quantity: One, fourteen section wing.

(c) Material.

IOL:

D. **SPECIAL CONSIDERATIONS:**

1. There will be 15 beds permanently assigned to the Neuropsychiatry Department, located on Ward Fourteen, that will share the ward's logistical support. One medical officer, a psychiatric nurse, and three Neuropsychiatric Technicians will be assigned to augment the staff on Ward Fourteen.

2. The psychiatrist with the psychiatric nurse as back-up will float to the Casualty Receiving Area as needed.

3. The NP Techs on Ward Fourteen will consult with ward personnel about other Neuro-psychiatric patients admitted to other hospital areas.

E. **WORKLOAD:**

1. Average daily admissions.

(a) Steady state = 80 admissions/day; 54 surgical, 26 medical cases.

(b) Peak state = 120 admissions/day; 80 surgical, 40 medical cases.

2. Anticipated neuro-psychiatric workload over a 30 day period.

SERVICE	CODE	DIAGNOSIS	DESCRIPTION
Medical	301	Psychoses	Severe All Cases
Medical	304	Acute Stress	Severe Combat Reaction
Medical	306*	Alcohol Dependency	Moderate All Cases Syndrome
Medical	308*	Drug Dependency	Severe Addiction.(Not Alcohol)
Medical	309*	Drug Dependency	Moderate Improper Use(Not Alcohol)

Notes:

* Consultant role treated on Medical Ward.

After discharge but before return to unit, patient with diagnosis #304 would be referred to the C. F. R. P. for future treatment not to exceed 14 days at the Combat Zone Hospital.

F. **ORGANIZATION:**

1. Responsibility. The Head, Neuropsychiatry Department, who is responsible for psychiatric care for all patients admitted to the hospital, reports to the Director, Medical Services. The psychiatric nurse reports to the Patient Care Coordinator for Inpatient Wards and the Head, Neuropsychiatry Department. The Leading Petty Officer will report to the Head, Neuropsychiatry Department via the Psychiatric Nurse.

2. Organization chart.

HEAD, MEDICAL DEPARTMENT

PATIENT CARE HEAD, NEUROPSYCHIATRY

COORDINATOR DEPARTMENT

PSYCHIATRIST

PSYCHOLOGIST

PSYCHIATRIC NURSE

LPO NP TECH

NP TECHS

3. Staffing.

(a) Criteria.

(1) Head, Neuropsychiatry Department, nurse, and LPO NP Tech are assigned permanently to AM watch and take call on night watch.

(2) One NP Tech is assigned the night watch on Ward Fourteen and is on call to other hospital areas.

(b) Special qualifications.

(1) All staff must have special training in neuropsychiatry field.

(2) NP Techs must have previous neuropsychiatry ward experience.

(c) Staffing pattern: Two 12-hour watches.

4. Assignments by billing sequence number: See TAB A, page 8.

5. Watch bill: See TAB B, page 9.

6. Special Watches: N/A

G. **TASKS:**

Task		Method
1. EVALUATE PATIENT	1.1	After referral by casualty receiving area physician, patient will be evaluated by psychiatrist, or available staff, and the pertinent psychiatric history will be documented on SF 539.
	1.1.A	Apply leather cuff, if indicated, IAW TABs C-1 and C-2 (although may be done in Casualty Receiving).

2.	PERFORM ADMISSION HISTORY AND PHYSICAL	2.1	Psychiatrist, or available staff will perform admission history, physical and mental exam to include status examination.
		2.2	Psychiatrist will formulate a diagnosis following currently accepted criteria (TAB F-2) and treatment plan Standard Combat Treatment Plan, and outline treatment plan on SF 509.
3.	INITIATE MEDICAL EVALUATION	3.1	If treatment in excess of 72 hours is estimated, initiate medical evacuation.
4.	REFER TO CFRP	4.1	If combat stress reaction, patient's suitability will be evaluated via medical hold observation for treatment not to exceed 14 days.
5.	RECORD NARRATIVE SUMMARY	5.1	Psychiatrist will prepare a narrative including chief complaint, admission diagnosis, history of present illness, past medical history, mental status examination, physical, laboratory studies completed, hospital course, discharge diagnosis, recommendations for future treatment.
6.	ASSIGN ICU PERSONNEL	6.1	Psychiatric nurse will make patient assignments. LPO NP will assign NPs to the following: Chow times. Cleaning details. Group therapy sessions.
7.	PERFORM LEADERSHIP	7.1	Provide training and TASKS supervision to enhance staff clinical and administrative abilities.
8.	PROVIDE CONTINUING EDUCATION	8.1	Provide orientation to Ward Fourteen IAW TAB E-3
9.	PROVIDE SUPERVISION	9.1	Psychiatric Nurse will supervise all nursing activities.
		9.2	Provide performance counseling to NP Techs on a continuing basis.
		9.3	Provide orientation and assistance to NP Techs assigned to Ward Fourteen.
10.	MONITOR INCIDENTS	10.1	Incidents will be reported on Incident Report Sheet, reviewed by Patient Care Coordinator and sent to Head, Neuropsychiatry Department.
		10.2	Head, Neuropsychiatry Department will monitor incident reports and counsel staff as needed.

H. **STANDARD OPERATING PROCEDURES:** See TAB C, page 10.

I. **CLINICAL POLICIES/GUIDELINES:** See TAB D, page 41.

J. **STANDARDS AND JOB DESCRIPTIONS:** See TAB E, page 46.

K. **DOCUMENTATION:**

1. References: See TAB F, page 58.
2. Forms: See TAB G, page 59.

TAB A

ASSIGNMENTS BY BILLET SEQUENCE NUMBER

Billet	Designator	Rank	NumberTitleSpec.	CodeRate
1. Medical Corps				
	41029	Head, Neuropsych	2100/0115	0-5
	41049	Psychiatrist	2100/0115	0-4
	41069	Psychologist	2100/0851	0-4
2. Nurse Corps.				
	34029	Hd. Amb. Care	2900/1930	0-5
	34049	Amb. Care Nurse	2900/0935	0-3
3. Hospital Corpsmen.				
	41019	Psych Tech	0000/HM	E-5
	41021	Psych Tech	0000/HM	E-5
	41039	Psych Tech	0000/HM	E-3
	41041	Psych Tech	0000/HM	E-3

* Permanent watchstander.

TAB B

WATCH BILL FOR NEUROPSYCHIATRY DEPARTMENT

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers																					
41029	A	A	A	A	E	A	A	A	A	A	A	A	E	A	A	A	A	A	A	A	E
41049	A	A	A	A	A	E	A	A	A	A	A	A	A	E	N	N	N	N	N	N	E
41069	N	N	N	N	N	N	E	N	N	N	N	N	E	A	A	A	A	A	A	E	N
Nurse Corps																					
34029	A	A	A	A	A	E	N	N	N	N	N	N	N	E	A	A	A	A	A	A	A
34049	N	N	N	N	N	N	E	A	A	A	A	A	A	A	E	N	N	N	N	N	E
Hospital Corpsmen																					
41019	A	D	A	E	A	A	A	A	A	D	A	E	A	A	A	A	A	D	A	E	A
41021	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D	N
41039	N	E	D	N	N	N	N	N	N	E	D	A	A	A	A	A	A	E	D	A	A
41041	A	D	A	E	A	A	A	A	A	D	A	E	A	A	A	A	A	D	A	E	A

KEY:

A = AM watch (0700-1900).

N = Night watch (1900-0700).

E = Excused.

D = Duty.

TAB C

PROCEDURES

INDEX

TAB C-1

MANAGEMENT OF THE VIOLENT PATIENT

A. **PURPOSE:** To control the overactive and/or assaultive patient to prevent harm to self and others.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Leather cuffs and belts.

2. Straight jacket (optional).

3. Sheets.

4. Sedative drugs.

5. Hypnotic drugs - Oran Benzodiazapines.

6. Anti-psychotics.

D. **CRITERIA:**

1. Physical restraints will be used only when psychological methods fail to calm a patient.

2. Patient will be restrained with a minimum of struggle.

3. Psychiatrist will write orders. In an emergency situation, the nurse may place a patient on specific precautions based on the nursing assessment.

E. **STEPS:**

1. Remove clothing; underwear may be left on. Cover patient with hospital gown. Once restrained, may be draped or bed sheets used.

2. First use verbal restraint methods to calm agitated patient.

(a) Use empathic, calm approach, and attitude to obtain patient's confidence.

(b) Demonstrate authority with voice, uniform, knowledge of hospital ways.

(c) Provide activities to keep patient occupied, interested, and calm.

(1) Assist with time structure.

(2) Set firm limits.

(3) Reinforce positive behaviors.

3. Show force to patient when persuasion and reasoning do not achieve results.

(a) Gather several corpsmen.

(b) Do not touch patient.

(c) Insist patient follow orders and no harm will be done to him.

4. When verbal restraint is ineffective use chemical restraints (sedatives, hypnotic drugs).

5. When verbal and chemical restraints fail, apply physical restraints (leather cuffs). (See TAB C-2 for technique.)

6. Separate fighting patients.

(a) Get behind each patient and clasp arms around patient's arms and chest.

(b) Hold patient against you.

(c) Place your knees against the back of the patient's knees to put him off balance.

(d) NEVER place your arm around patient's neck.

7. Disarm patient with weapon.

(a) Work as a team.

(b) One member attracts patient's attention.

(c) Other member dislodges the weapon.

(1) If weapon is a chair, use another chair. Lock your chair into his and pull down.

(2) If weapon is smaller object, throw a pillow into patient's face or a blanket over him.

(3) If weapon is a sharp object, hold a mattress or litter in front of you and back patient into the wall.

F. **RESPONSIBILITY:**

1. Charge Nurse on wards.

2. Head, Neuropsychiatry Department.

TAB C-2

GUIDELINES FOR USE OF RESTRAINTS

A. **PURPOSE:**

1. Application of restraint is advisable only in a limited number of cases. The purpose of restraint is to protect, never to punish. The protective purposes are:

(a) To protect the patient from himself.

(b) To protect others from the patient in episodes of extreme agitation.

(c) To protect the treatment regime on the ward from extremely severe disruption.

B. **RESTRAINT ORDERS:**

The use of physical restraints usually requires a written order from a Medical Officer who has conducted a clinical assessment of the patient and has determined that the procedure is necessary. All written orders for the use of restraints shall be timC-limited and shall not be written on a PRN basis. The automatic time limit for restraint orders is twelve hours from the time of the restraint unless otherwise specified. Restraints may be discontinued prior to the automatic time limit if ward personnel and nurses deem it clinically appropriate and inform the medical officer. The order must specify type of restraint, for what behavior, and the length of time to leave in place.

C. **REPORT AND REVIEW:**

All uses of physical restraint shall be reported daily at morning report to Head, Neuropsychiatry Department, who shall review all uses of restraint and investigate unusual or possibly unwarranted patterns of utilization.

D. **RESTRAINT EQUIPMENT:**

1. Leather cuffs and belts (designed and manufactured specifically for restraint). Usual means for physical restraint.

2. Straight jackets. An alternative for above but with no advantage over cuffs.

3. Posey belts and other cloth vests or girdles. Not suitable for agitated psychiatric patients.

4. Ace wraps and other bandages. These are commonly used as "reminder" restraints. They are useful to protect surgery sites, IV sites, etc. They are of no value for agitated patients and shall not be used to control such patients.

5. Sheets. Sheets may be used for restraint across chest of patient, but increased attention must be paid to circulatory and respiratory needs of the patient.

6. Gloves. Gloves can be used to restrain a confused patient's ability to manipulate objects.

E. **CRITERIA:**

1. Restraint orders will be renewed every 12 hours.

2. Circulatory checks will be monitored on restrained extremities every 4 hours.

3. All persons applying restraints will receive proper training.

F. **PRECAUTIONS:**

1. When 2 point restraints are used, attach to diagonal limbs to prevent inadvertent injury by rolling from the bed.

2. Check circulation in restrained limb to prevent permanent damage to limb from occluded vessels when restraint is too tight.

G. **STEPS:**

1. Prior to application of restraint:

(a) Validate that no other alternative can be used to calm patient.

(b) Obtain Doctor's order for restraint. In the case of an emergency, obtain order within one hour of restraints being applied.

(c) Get ample help: 4 persons.

(d) Take patient to area where there is minimal chance of injury, if possible.

(e) Approach patient with firmness and a controlled temper.

(f) Explain the purpose of the restraint.

(g) Remove sharp objects from patient's pocket and uniform.

2. Apply restraints.

(a) One person keep patient's attention.

(b) One person out of patient's vision give the signal to restrain.

(c) One person on each side grasp an arm.

(d) One or two persons grasp the legs.

(e) Bring the patient to the deck, preferably on his stomach.

(f) Fold the arms across the back and hold the wrists.

(g) Cross the legs and flex the knees, holding the ankles.

(h) Apply leather restraints.

(i) Place patient on a bed.

3. Manage the restrained patient:

(a) Check patient every 15 minutes about nourishment, and use of toilet. Patient is dependent upon nursing staff to have needs met.

(b) Monitor vital signs, circulation, and neurological status at least

every 4 hours.

H. **POSSIBLE ANTI-THERAPEUTIC EFFECTS FROM USE OF PHYSICAL RESTRAINTS ARE:**

1. Restraint is difficult to control. Personnel who don't understand its dangers indiscriminately apply restraints to combative, destructive, moderately disturbed, and even restless patients. The net effect of such activity is vastly increased ward management problems.

2. Restraint may be physically injurious, not only to the patient, but to staff personnel as well.

3. Restraint feeds frustration. It produces aggression, resentment, hate, desire for revenge; all negative emotions. Keep in mind how hostile and frustrating the world might look to someone who is restrained. It may cause the patient to frequently upset the ward routine.

4. Restraint creates an atmosphere of punishment. The patient in restraints naturally comes to feel that this denial of freedom of movement is a penalty for actions that he could not control. Too frequently staff members add to this prison atmosphere by threatening the use of restraint whenever a slight management problem arises. The ward then becomes a domain ruled by fear instead of understanding.

5. Restraint is an indignity to the patient's person. It is an insult to his self-esteem.

6. Restraint means more work. Restraining a patient requires personnel on wards to stop their normal work and assist or stand-by in the restraint. This puts a burden on everyone. A patient requires the assistance of several people to eat, use the head, receive medications.

I. **RESPONSIBILITY:**

1. Head, Neuropsychiatry Department for orders.

2. NP Techs for application.

TAB C-3

ESCAPE, ASSAULT, AND SUICIDE PRECAUTION POLICY

A. **PURPOSE:** To establish policies and guidelines for the management of patients at risk for escape, assaulting others or suicide and for outlining responsibilities in response to a completed escape.

B. **DEFINITIONS:**

Escape - unauthorized patient absence from ward/hospital.

C. **EQUIPMENT, SUPPLIES AND FORMS REQUIRED:**

Incident Report Form, NAVMED 6010/14.

D. **CRITERIA:**

1. When suicide precautions have been set using special watches, a staff member will be with patient at all times.

2. Absent psychiatric patients will be reported to security immediately.

E. **STEPS:**

1. Place a patient on escape, assault, or suicide precautions when it is believed patient will try to harm self, others or escape.

(a) Written order by Medical Officer is required.

(b) Head, Neuropsychiatry Department must review orders daily.

2. Observe these rules when precaution order is implemented:

(a) Search the patient's person and his field bed area and remove all hazardous objects.

(b) Have the patient change into clean pajamas in the presence of a staff member.

(c) If possible, assign the patient to a bed close to the nursing station for closer observation.

(d) Restrict the patient to the ward and assign a staff member to watch the patient.

3. Implement one of the following types of watches for suicide, assault, or escape precautions:

(a) Loose (or awareness) watch 1:1 - patient is kept within general eyesight of a designated staff member but is usually allowed to go to the head, or anywhere on ward as long as assigned staff member is continually aware of patient's whereabouts and makes frequent visual checks on patient.

(b) Special watches:

(1) Eyesight 1:1 - patient is kept within eyesight of a designated staff member **AT ALL TIMES**. At no time is the patient to be left alone. He must be accompanied to the head, and all areas within hospital.

(2) Close (or arms length) 1:1 - assigned staff member must be

within arms reach of patient at all times. (Generally used with extremely suicidal or self-destructive patients). In the case of assault precautions, the staff member will remain outside arms reach of the patient but close enough to intervene as appropriate in potentially assaultive situations.

4. Remove suicidal or homicide hazards from patient as is reasonable in combat zone hospital environment.

(a) Patient belongings: Nail file, scissors, razor blades, eyeglasses, false teeth, matches, and cigarettes.

(b) Environmental hazards: Lights, switches, sockets, projections from which a patient could hang, topical supplies, cleaning fluids, ink, insecticides, torn linen, dental floss, string, ribbon, belts, ties, scarves, hose, glass, pins, paper clips, thumb tacks, bones, wads of cotton, hair, toilet tissue.

5. Conduct searches for reported lost articles that may be potentially dangerous.

(a) Look in hiding places - mattresses, linens, books, plumbing, drains, decks, window flaps, etc.

6. Initiate a search for a missing psychiatric patient.

(a) Charge Nurse is Search Coordinator. She will notify, in order, the following:

(1) Security.

(2) Ward Medical Officer.

(3) Head, Neuropsychiatry Department.

(4) Patient Care Coordinator.

(b) Staff Corpsman will:

(1) Search wards in hospital.

(2) Record time patient escaped or was first observed absent, recent observations of patient's behavior, and the situation of the escape itself.

(c) Charge Nurse will assure completion of an Incident Report.

(d) Head, Neuropsychiatry Department will:

(1) Review clinical aspects of case.

(2) Evaluate threat of patient to self and others

(3) Notify Security of possible destination of patient.

F. **RESPONSIBILITY:**

1. Charge Nurse to implement policy, or search.

2. Medical Officer - to write orders.

TAB C-4

ROUTINE MEDICATION TIMES

A. **PURPOSE:** To standardize medication administration times so that nursing service and pharmacy can perform this task most efficiently.

B. **SCHEDULE:**

1. Routine times.

(a) qd 0900

(b) bid 0900-2100

(c) tid 0600-1400-2200

(d) qid 0600-1200-1800-2400

(e) q4hr 0200-0600-1000-1400 etc

(f) q6hr 0600-1200-1800-2400

(g) q8hr 0600-1400-2200

(h) q3hr 0300-0600-0900 etc

(i) q12hr 0600-1800

(j) qhs 2200

(k) Daily insulin 0700.

(l) Insulin sliding scale 0700-1100-1600-2100.

2. Special considerations for adjusting times.

(a) Triple IV antibiotics are ordered.

(b) Diuretics are ordered: best to administer before 2200.

(c) Oral antibiotics scheduled for 2400 should be given at 2200 so sleep is not interrupted.

C. **CRITERIA:**

Medications will be given at routine times unless adjusted for reason specified.

D. **STEPS:**

1. Complete medication cards and MAR sheet with times stated above.

2. For medication times differing from the routine, note this in margin of Doctor's Orders Sheet, SF 508, prior to sending to Pharmacy.

E. **RESPONSIBILITY:**

Charge Nurse.

TAB C-5

GUIDELINES FOR ADMINISTRATION OF CONTROLLED SUBSTANCES

A. **PURPOSE:** To provide guidelines for administration of controlled substances.

B. **DEFINITION:** Narcotics and controlled drugs are medications that by law must be stored within a locked system and inventoried for accountability.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Narcotics and controlled drugs.

2. Medication locker with double lock system.

3. Narcotic and Controlled Drug Inventory - 24 hours, NAVMED Form 6710/4.

D. **CRITERIA:**

1. All narcotics and controlled substances will be stored in a medication locker with a double lock.

2. The keys to the medication locker are to be in the personal custody of the registered nurse.

3. All narcotics and controlled substances will be logged out by a registered nurse.

4. All narcotics and controlled substances will be verified each watch concurrently by nurses reporting on and off duty.

E. **STEPS:**

1. Nurses reporting on and off duty will count drugs on hand and verify on each watch.

2. Both nurses will sign NAVMED 6710/4 Narcotic and Controlled Drug Inventory. Verification will include drug, patient, amount, and serial number.

3. Report any discrepancies to Patient Care Coordinator and Pharmacy and file an incident report.

4. Only a registered nurse may receive narcotics and controlled substances delivered by pharmacy personnel.

5. When logging out drugs, complete the following information on NAVMED 6710/4: patients last name, first initial, amount dispensed, ordering physician, person withdrawing, and amount of drug remaining.

6. When using only a portion of the total amount expended, document the amount used, and discard the unused portion with a witness present.

7. When a dose is damaged, contaminated, portion wasted, or refused by the patient, destroy the dose. Document the event on SF 6710/1.

8. The Patient Care Coordinator will inventory and verify drugs on hand monthly. Document on SF 6710/4.

F. **RESPONSIBILITY:**

1. Charge Nurse.
2. Patient Care Coordinator.

TAB C-7

NON-AMBULATORY PATIENT MEALS

A. **PURPOSE:** To stipulate specific uniform requirements for ordering meals for bed-ridden patients.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Ward Diet Roster Form.

2. Twenty-four Hour Intake and Output Form.

3. Bedside tray for field bed.

4. Types of diet available:

(a) High calorie - high protein.

(b) Dental soft.

(c) Dental liquid.

(d) Full liquid.

(e) Clear liquid.

(f) Forced fluids

(g) Tube feedings from pharmacy.

NOTE: No sodium restricted diets will be provided.

D. **CRITERIA:**

1. Non-ambulatory patient meals are ordered accurately and in time.

2. Three hot meals will be served each twenty-four hour period.

3. Six types of menus are available.

4. Non-infectious patients may assist in feeding non-ambulatory patients.

E. **STEPS:**

1. Order diets.

(a) Prepare a ward diet roster (TAB J-17) by 0400 each day. Supplies of rosters must be maintained on each ward and may be obtained from operating management service.

(b) Specify appropriate diet from selection of six options.

(c) Complete form as indicated, providing at minimum, patient name, assigned bed and diet order.

(d) Enter any special requirements as indicated.

(e) Make diet changes by calling Food Service. Changes will be

accepted up to:

(1) 0400 for breakfast.

(2) 0900 for lunch.

(3) 1400 for supper.

2. Prepare patient for meal.

(a) Wash patient's hands and face.

(b) Place patient in an upright, comfortable position.

(c) Clear bedside table and place near patient.

3. Serve tray to patients in accordance with TAB C-9.

4. Assist patient with meal as needed.

5. Record fluids consumed on Twenty-four Hour Intake and Output Form if applicable. Record how diet was tolerated in nursing notes.

6. Give oral hygiene to patients as needed.

F. **RESPONSIBILITY:**

1. Charge Nurse.

2. Senior Corpsman.

G. **REFERENCES:**

1. NAVMED P5066-A.

2. NAVSUP PUB 436, Standard "B" Medical Rations for the Armed Forces.

3. Food Service Department Standard Operating Procedure (Chapter 10).

TAB C-8

WARD MEAL DELIVERY AND RETRIEVAL SCHEDULE/PROCEDURE

A. **PURPOSE:** To promulgate uniform procedures to accomplish non-ambulatory patient meal service.

B. **DEFINITION:** N/A.

C. **CRITERIA:** Meals will be delivered hot to the correct patients on each ward. Meals will be served and cleaned up within one hour of delivery to ward.

D. **STEPS:**

	Ward	Delivery	Pickup
BREAKFAST	2	0530	0630
	4	0540	0640
	6	0550	0650
	7	0600	0700
	5	0610	0710
	3	0620	0720
	1	0630	0730
LUNCH	2	1030	1130
	4	1040	1140
	6	1050	1150
	7	1100	1200
	5	1110	1210
	3	1120	1220
	1	1130	1230
DINNER	2	1630	1730
	4	1640	1740
	6	1650	1750
	7	1700	1800
	5	1710	1810
	3	1720	1820
	1	1730	1830

1. Two Mess Specialists will be assigned at each meal to deliver and serve patient meals. Each MS will be assigned responsibility for specific wards.

(a) MS #1 is responsible for Wards 1, 5, 6, and 2.

(b) MS #2 is responsible for Wards 3, 7, and 4.

2. When the delivery vehicle arrives at each ward, the responsible Mess Specialist will notify the responsible Charge Nurse.

3. Each Ward Charge Nurse will assign a staff corpsman to assist during meal periods.

4. The responsible HM and MS will unload all gear required for each respective ward and carry it into the ward.

5. As each ward is delivered, the vehicle will move on to the next ward in sequence.

6. On the ward, the MS will:

(a) Set up a meal assembly line.

(b) Portion items required to support each diet ordered on the roster.

(c) Leave the remaining material set up on the ward.

(d) Proceed to the next assigned ward.

7. On the ward the HM will:

(a) Present and hold the necessary trays for each patient while the MS portions the meal.

(b) Deliver the meal to the appropriate patient.

(c) Dispense appropriate beverages.

(d) Dispense any remaining food consistent with specific diet orders.

(e) Retrieve soiled gear.

(f) Stage soiled gear adjacent to the exit vestibule for subsequent pick up by MS.

8. Upon completion:

(a) Mess specialist 1 retrieves soiled mess gear from Wards 3, 7, and 4.

(b) Mess specialist 2 retrieves soiled mess gear from wards 1, 5, 6, and 2.

9. Assigned vehicle will pick up soiled mess gear and deliver to scullery.

10. Assigned mess specialist 1 and 2 will assist in scullery clean up of soiled ward gear.

11. Wash, rinse, and air dry ward mess gear.

TAB C-9

SUPPLEMENTAL FEEDINGS

A. **PURPOSE:** To prescribe policy and procedures for obtaining subsistence that is medically required at other than routine meal periods.

B. **DEFINITION:** N/A.

C. **CRITERIA:**

Patients whose clinical conditions require supplemental feedings receive same.

D. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:** N/A.

E. **STEPS:**

1. The Combat Zone environment, austere staffing, limited storage capacity, and absence of single service and/or individual portion containers dictate that supplemental feeding be kept to an absolute minimum and that each be physician prescribed.

2. When a supplemental feeding is required, the ward charge nurse will:

(a) Verify that a chart entry supports the order.

(b) Notify food service by phone of the requirement, providing patient's name, ward number, diet order, and subsistence items required.

(c) Request the time that the order be ready for pick-up (not less than 2 hours after request).

(d) Dispatch an individual to pick up the items at the agreC-upon time.

3. Food service will:

(a) Accommodate supplemental feeding requests.

(b) Obtain required subsistence items and package them suitably.

(c) Release them to the ward representative.

TAB C-10

TWENTY-FOUR HOUR NURSING SERVICE REPORT

A. **PURPOSE:** To provide a written communication of significant patient information to the Director of Nursing Service and the Commanding Officer.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Form, NAVMED 6550/3.

D. **CRITERIA:**

1. The Twenty Four Hour Nursing Service Report is to be completed by the Charge Nurse at the end of each watch.

2. Each entry is to be completed in black ink, legible and concise.

E. **STEPS:**

1. Complete body of report. Include:

(a) Patients name, age, grade, rate, and diagnosis.

(b) Approved abbreviations.

(1) AM (AM watch).

(2) PM (PM watch).

(3) DOS (Day of surgery).

(4) POD (Post-op day).

(5) VSL (Very serious list).

(6) SL (Serious list).

(7) DD (Patient expired).

(8) DOP (Day of significant procedure).

2. Narrative section guidelines.

(a) State brief history.

(b) Give reason for admission, diagnosis.

(c) State significant procedures or surgery performed, indicate results.

(d) State significant treatments or progress.

3. Use first block for relaying information such as number of expectants, expected air evacs, and staffing needs.

4. List the following patients daily:

(a) Flag officers (O-7).

(b) Captains and colonels (O-6).

(c) Fleet Hospital staff regardless of rate or rank.

(d) Foreign military/POW's.

(e) ICU, and recovery room keeps.

(f) Serious ill (SL) and very serious ill (VSL) patients.

(g) Deaths; include time.

(h) Accident or unusual occurrences (i.e. drug injection, self-inflicted injury).

(i) Civilian humanitarian.

F. **RESPONSIBILITY:**

Charge Nurse.

G. **REFERENCES:**

Nursing Procedure Manual, NAVMED P-5066.

TAB C-11

PROCEDURES FOR RELEASE OF MEDICAL INFORMATION

A. **PURPOSE:** To provide procedures of release of medical information within the hospital.

B. **DEFINITION:** Medical Information - Information contained in the health or dental record of individuals who have undergone medical examination or treatment.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:** N/A.

D. **STEPS:**

Upon presentation of requests for medical information refer to procedures contained in the following references:

1. Manual of the Medical Department.

2. Freedom of Information Act, BUMEDINST 5720.8.

3. Personal Privacy and Rights of Individuals Regarding Records, SECNAVINST 5211.5.

4. Availability of Navy Records, Policies, SECNAVINST 5720.42.

E. **GENERAL GUIDELINES:**

1. Information contained in health care records of individuals who have undergone medical or dental examination or treatment is personal to the individual and is therefore considered to be of a private and confidential nature. Information from such health care records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, should not be made available to anyone except as authorized by the patient or as allowed by the provisions of Manual of the Medical Department Chapter 23 and the Privacy Act of 1974 as implemented by SECNAVINST 5211.5 series.

2. Release of information will be coordinated by the Patient Affairs Officer.

3. Personal information of non-medical nature will not be released.

4. Personnel in the patients chain of command may be provided with information required to conduct command business but will be referred to the Patient Affairs Office.

5. Release of information will conform to local command and superior command policy.

6. All Department Heads shall ensure wide dissemination of this information and compliance with procedures outlined herein.

F. **RESPONSIBILITY:**

1. Director of Administration.

2. Patient Affairs Officer.

3. Charge Nurse or Assistant.

TAB C-12

PROCEDURE FOR PICK-UP AND DELIVERY OF HOSPITAL LAUNDRY

A. **PURPOSE:** It will be logistically impossible to pick up and deliver laundry at each individual ward and CSR. Therefore, this procedure establishes central collection points and the methodology for preparing laundry for turn-in.

B. **DEFINITIONS:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Canvas laundry bags.

2. Request for clean linen/laundry.

D. **CRITERIA:** N/A.

E. **STEPS:**

1. Designated Laundry Petty Officer will:

(a) Set up laundry bags, tagging one for bed linen, one for clothing (including patient clothing), and one for contaminated laundry.

(b) Daily at 0800, take the soiled laundry to the nearest Clinical Work Space along with a request for the next day's linen/laundry supply.

(c) Distribute cleaned patient clothing.

2. Linen Control Clerks.

(a) Pick-up and receipt for hospital laundry at each Clinical Work Space.

(b) Collect Requests For Clean Linen/Laundry.

(c) Fill requests submitted the previous day and return cleaned patient clothing.

TAB C-13

PROCEDURE FOR HANDLING AND LAUNDERING CONTAMINATED LINENS

A. **PURPOSE:** The Combat Zone Fleet Hospital will generate a significant amount of contaminated linen within the operating rooms and treatment wards. These items will require special handling and laundering to prevent the spread of infection.

B. **DEFINITION:** Contaminated laundry is defined as those items requiring special disinfection and laundering to preclude the spread of infection.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Chlorine bleach solution.

2. Latex gloves.

D. **CRITERIA:** N/A.

E. **STEPS:**

1. Hospital ward personnel will bag contaminated laundry separate from regular laundry. Gloves are to be worn when handling contaminated laundry.

2. Contaminated laundry will be receipted by the Linen Control Clerks and delivered to the laundry.

3. At the Laundry all contaminated laundry will be segregated from that requiring only routine processing.

4. Based on the next day's requirements and current inventory the contaminated laundry will be assigned a processing priority.

5. The contaminated laundry will be processed as follows:

(a) Presoak the contaminated laundry for 60 minutes in a chlorine solution of 50 ppm.

(b) Wash the linen in hot water using a normal cycle.

6. Once laundered these items will be placed in inventory for re-issue.

F. **RESPONSIBILITY:**

The Head, Environmental Health Department is responsible for routinely monitoring the handling and laundering of contaminated items to preclude the spread of infections.

CAUTION: Extreme care must be taken to avoid contact with the contaminated laundry to prevent the spread of infection to laundry and other hospital personnel.

TAB C-14

PATIENT PROCEDURES FOR HANDLING EXPATRIATED PRISONERS OF WAR

A. **PURPOSE:** To detail patient handling procedures for expatriated prisoners of war within the fleet hospital.

B. **DEFINITION:**

Expatriated prisoners of war (EPW) - those patients who require treatment who are prisoners of U.S. or allied combat forces.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Restraints (theater command military police or hospital issue).

2. Others as specified in admission procedures (all forms will be marked with the words "Prisoner of War" or "EPW").

D. **STEPS:**

1. Upon presentation of EPW to functional area, notify Security Department.

2. Upon admission to Casualty Receiving, Security will be responsible for the following notifications:

(a) Theater command military police (MP) headquarters.

(b) Executive Officer.

(c) Director of Nursing.

(d) Director of Administration.

3. Perform essential life saving care.

4. Inform MP that custody of patient will not be assumed by hospital staff and that MP will retain custody of EPW until relieved by appropriate MP headquarters staff or patient is transferred to EPW holding center (external to hospital).

5. After treatment, have corpsman or litter bearer escort MP and EPW to next functional area charge nurse. Admissions packet, correctly annotated will be delivered by hand to charge nurse.

6. During course of treatment, patient will be guarded by MP and/or restrained until treatment is terminated.

7. Movement to another functional area will be reported to Security.

8. EPW's will be fed either on the ward or in the general mess. If allowed to eat in the general mess, EPW's will be accompanied by MP guards.

E. **RESPONSIBILITY:**

CMAA/Security.

TAB D

CLINICAL POLICIES/GUIDELINES

INDEX

TAB D-1

MENTAL HEALTH POLICIES

A. Cases with potentially recurrent or chronic psychotic episodes, or any other disorder which cannot be treated and returned to useful duty in the theater within the evacuation policy, will be evacuated to CONUS as rapidly as practical. This procedure normally requires an initial 4-day evaluation period to rule out a restorable diagnosis. Evacuation priority is routine.

B. Personality or Conduct Disorder without concurrent psychiatric or medical illness will be discharged to duty for administrative action. A psychiatrist is required by regulation to make the diagnosis in some legal cases and to support chapter discharge for Personality Disorder.

C. Stress disorders (including battle fatigue and noncombat adjustment disorders) will be treated as close to their unit and as quickly as possible, with positive expectation of rapid return to duty. Those patients who fail to respond will have successive treatment at each echelon of care before final evacuation to CONUS (to the extent the tactical situation allows) in order to maximize RTD and minimize chronic disability.

D. Alcohol abuse cases whose service records and medical status indicate good RTD potential will be detoxified as far forward as practical (usually Echelon 1, 2 or 3) and be returned to their units. No Alcohol Rehab Program is incorporated into DEPMEDS, but some outpatient follow-up is assumed. Command should have the option of adding a 21 day Inpatient Rehab Program to decrease risk of relapse in 25% of alcohol dependence, moderate cases. Alcoholics in withdrawal whose service records or medical status indicate poor potential for RTD will be stabilized, then evacuated to Echelon 4 to complete detoxification and administrative disposition. Only those with significant medical/surgical problems requiring further treatment will be evacuated to CONUS.

E. Drug misusers whose service records and medical status indicate good RTD potential will be detoxified as far forward as practical (usually Echelon 1, 2 or 3) and be returned to their units. No Drug Rehab Program is incorporated into DEPMEDS, as current regulations will subject those who need more than simple counseling/"corrective education" to either involuntary separation or legal punishment. Drug abusers who need medical treatment but whose service records indicate poor potential for RTD will be stabilized, then evacuated to Echelon 4 to complete detoxification and administrative disposition. Only those with significant medical/surgical problems requiring further treatment will be evacuated to CONUS.

TAB D-2

SURGICAL GUIDELINES

A. Whenever abdominal, thoracic, or contaminated surgery is being conducted, simultaneous specialty (Orthopedic, Neurosurgical, Ophthalmological, or Vascular) will not be performed.

B. Operating microscopes are available at COMMZ only. Microscopes are non-supportable in combat zone. They will be placed in a special augmentation package for Echelon 4. (If damage occurs, microscopes will be exchanged; no repair will be done in the theater.)

C. All casting materiel is documented in the Casting "G" module using one of the "G" tasks. Time has been documented for the cast tech for casting in the OR as well as for checks of splints, casts, pins, and fixateurs on the wards. This time is 4 minutes once a day.

D. In all open fractures of extremities a combination of external fixture’s and plastered casting material will be used. For modeling purposes, 75% of the patients will have external fixture’s and 25% will receive plaster material.

E. Irrigating Fluids:

1. DEPMEDS recognizes the requirement for adequate amount of irrigating fluids. However, emphasis should be placed on using the minimal amount necessary because of the tremendous impact on the logistical system.

2. There will be 2 liters of normal saline per operative case.

F. Dressings will ordinarily not be changed prior to day 4 post initial wound debridement at which time the wound will be examined in the OR for further debridement or delayed primary closure. However, a blood soaked dressing, excessive hemorrhage, and/or sepsis may necessitate wound examination and redressing outside the OR. In the database, all wounds that render the patient non-return to duty within the evacuation policy have a dressing reinforcement in 20% of patients. This category of patients otherwise have dressing reapplied as indicated above in the OR if the stay in theater exceeds 4 days. Further, if the stay exceeded 8 days, another dressing change would be done. For patients returning to duty in the theater, the same policy is in use during initial 4 days and periodic dressing change is accomplished depending on the nature and severity of injury.

G. Blood recovery equipment (or Cell Saver) is available in DEPMEDS at Echelons 3 and 4 and will be used to the maximum extent practical. Anesthesia personnel are responsible to set up and maintain this equipment during operative procedures. Theoretically, this equipment may be used in contaminated and septic cases; however, it is not applied in these cases in the database. The machine requires a liter of sterile saline with 30,000 units of heparin for primary and an additional liter of saline for each unit of blood recovered. Also, it requires a liter for cleaning. The cleaning of the equipment is modeled under the anesthesia area but will be performed by an operating room technician. The setup consumables are found in CSG 12 and cleaning consumables are in CSG 22.

TAB E

STANDARDS AND JOB DESCRIPTIONS

INDEX

TAB E-1

NEUROPSYCHIATRY DEPARTMENT EVALUATIVE STANDARDS

A. Standards for the Neuro-psychiatric Department will be carried out in accordance with DSM III.

B. Standard Operating Procedure for the Neuro-psychiatric Department is available on Ward Fourteen.

C. An order for leather cuff restraints is written.

D. Safety precautions are observed in caring for violent or suicidal patients.

TAB E-2

SAFETY PRECAUTIONS

SEE THE FOLLOWING TABS FOR PROCEDURES:

TAB E-3

ORIENTATION TO NEUROPSYCHIATRY DEPARTMENT

A. **PURPOSE:** To ensure that the Neuro-psychiatric Department staff are familiar with the physical layout of the Fleet Hospital, Ward Fourteen, equipment location, and routine procedures when they report for duty.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Drawing of the spaces.

2. Equipment lists of leather restraint locations.

3. Forms used.

D. **CRITERIA:**

l. Due to the short time frame between gear-up and operational mode, staff must be able to utilize equipment upon arrival.

2. It is assumed neuropsychiatric staff are familiar with caring for psychiatric patients and have been oriented to diagnoses to expect in combat zone areas.

E. **STEPS:**

1. Familiarize staff with most common psychiatric diagnoses to be sent and treatment protocols to be implemented.

2. Review procedures for applying leather cuff restraints.

3. Review the Neuropsychiatry Department SOP with personnel.

4. Conduct supplemental classes as needed.

TAB E-4.1

HEAD, NEUROPSYCHIATRY DEPARTMENT JOB DESCRIPTION

The Head, Neuropsychiatry Department is responsible for the psychiatric care of all patients treated. He reports to the Director, Medical Services.

THE HEAD, NEUROPSYCHIATRY DEPARTMENT WILL:

1. Set policies and procedures for psychiatric care given in the hospital.

2. Perform mental status exam.

3. Complete Short Form History and Physical (SF 539) for an admission within 24 hours of admission.

4. Formulate treatment plans to be implemented by nurse and NP Techs.

5. Document patient progress and treatment on Progress Notes at least every 2 days.

6. Make daily rounds on designated psychiatric admissions beginning at 0830 to evaluate and reassess treatment plans.

7. Be on call to Casualty Receiving Area for psychiatry admissions.

8. Monitor psychiatric patient care given by nurse and NP Techs.

9. Conduct weekly meeting with departmental staff.

10. Oversee an orientation and training program for departmental staff.

11. Provide training lectures to medical officers about combat psychiatric problems and treatment protocols.

12. Consult with ward medical officers about patient psychiatric problems.

13. Consult to "post-op" and "prC-op" care areas for staff and patients.

14. Provide group therapy sessions for hospital personnel to verbalize stress, anxiety of working in a combat hospital.

15. Approve all communication within and outside of the department.

16. Approve a monthly departmental watch bill.

17. Approve all personnel performance evaluations.

18. Prepare and submit required reports in final form.

19. Advise command on general mental health issues.

QUALIFICATIONS:

1. Designator 2100/2105 physician.

2. Board Certified General Psychiatrist with subspecialty Code 0115.

3. Fully credentialed.

4. Basic Cardiac Life Support (BCLS) certification.

5. Graduate Intermediate LMET course.

6. Completion of Fleet Hospital Operation and Maintenance Training Course recommended.

TAB E-4.2

PSYCHIATRIC NURSE JOB DESCRIPTION

The nurse is responsible for the nursing care given to all patients admitted to the hospital with psychiatric problems. Reports to Patient Care Coordinator and Head, Neuropsychiatry Department. Oversees nursing care provided by NP Techs.

THE PSYCHIATRIC NURSE WILL:

1. Usually be assigned to Ward Fourteen, in charge of fifteen beds reserved for psychiatric patients. Oversee the running of these beds under the direction of the psychiatrist.

2. Team with psychiatrist on rounds.

3. Assess, plan, implement, and evaluate patient care IAW Standards for Psychiatric Nursing Practice.

4. Assign duties to NP Techs.

5. Supervise and evaluate individual work performance in terms of patient care, staff relations, and efficiency of service. Prepare formal, written evaluations when required.

6. Coordinate patient care with other departments and service within the hospital. Promote good interpersonal and interdepartmental relationship.

7. Make herself available to nursing staff in "prC-op" and "post-op" areas to ventilate anxiety and stress of working in a combat zone hospital.

8. Consult with Charge Nurses about psychiatric problems that patients have.

9. Ensure that safety standards are observed when restraining a combative patient.

10. Ensure that suicide precautions are taken with a suicidal patient.

11. Conduct orientation and training classes for NP Techs and other interested hospital staff.

12. Counsel NP Techs about work performance identifying strengths and limitations.

13. Maintain confidentiality of information given by patients during therapy sessions.

14. Ensure that established policies, procedures, and routines are current and available in the Neuropsychiatry Department Standard Operating Procedure Manual.

15. Comply with established inventory procedures to account for narcotics, controlled drugs, and other dangerous substances.

16. Report all pertinent information to the patient care coordinator and Head, Neuropsychiatry Department.

17. Evaluate patients by observing, recognizing, recording, and reporting changes in patients' conditions, subjective and objective symptoms, reaction to medications, and response to therapy.

18. Approve watch schedules for NP Techs as directed, using staff policy for the hospital.

QUALIFICATIONS:

1. Designator 2900/2905, Psychiatric Nurse Subspecialty Code 1930.

2. Basic Cardiac Life Support (BCLS) certification.

3. Level IV certification for administering Parenteral Fluids and Blood Products IAW NAVMEDCOMINST 6550.3.

4. Restraint application certification.

5. Medication certification.

TAB E-4.3

LPO NP TECH JOB DESCRIPTION

The LPO NP Tech is directly responsible to the Psychiatric Nurse for the overall performance, military conduct, and appearance of NP Techs assigned to the Neuropsychiatry Department.

THE LPO NP TECH WILL:

1. Primarily assigned to Ward Fourteen, 15 beds designated for psychiatric patients.

2. Must be familiar with Neuropsychiatric Department "SOP" Manual.

3. Orient new NP Techs.

4. Assist NP Techs with therapy as needed. Serve as resource to NP Techs.

5. Make rounds to ensure NP Techs meet patient needs and work is completed efficiently.

6. Ensure NP Techs follow the established policies, procedures, and routines as available in the Neuropsychiatry Department Standard Operating Procedure Manual.

7. Maintain and order supplies needed specifically for the Neuropsychiatric Department.

8. Maintain all daily logs/records for the Neuropsychiatric Department.

9. Ensure safety standards are observed when restraining a combative patient.

10. Ensure that ordered suicide precautions are carried out.

11. Convey information to NP Techs about departmental changes.

12. Ensure NP Techs are familiar with hospital procedures for fire, patient evacuation, cardiac arrest code, and general safety procedures.

13. Counsel NP Techs about military bearing/protocols including career development.

14. Maintain good interpersonal relations with other hospital departments and staff members.

15. Maintain high standards of personal hygiene and conduct.

16. Report to and obtain assistance from psychiatric nurse as needed.

17. Ensure that all daily logs and records are completed correctly.

18. Prepare and submit monthly watch, quarters, and station bills.

19. Provide training classes for NP Techs.

20. Take call during night watch.

21. Perform other duties as assigned by psychiatric nurse or Head, Psychiatric Department.

QUALIFICATIONS:

1. Petty Officer (C-4 or above).

2. Completion of Neuropsychiatric Technician School, and has NEC 8485.

3. At least six months experience in psychiatric care is required.

4. Basic Cardiac Life Support (BCLS) certification.

5. Level II certification IAW NAVMEDCOMINST 6550.3 to initiate and monitor parenteral IV fluids.

6. Medication certification.

7. Restraint application certification.

8. Possess knowledge of hospital policies and procedures as well as military regulations, procedures, and protocols.

TAB E-4.4

NP TECH JOB DESCRIPTION

The NP Tech, responsible to the LPO NP Tech, will assist the Head, Neuropsychiatry Department and Psychiatric nurse in giving nursing care to patients with psychiatric disorders.

THE NP TECH WILL:

1. Primarily be assigned to Ward fourteen, fifteen beds designated for psychiatric patients.

2. Give nursing care IAW the standards for Psychiatric Nursing Practice.

3. Use therapeutic communication skills in interacting with patients.

4. Properly apply restraints to patients.

5. Enforce suicide precautions as ordered.

6. Administer oral psychotropic medications.

7. Provide emergency treatment to patients (CPR).

8. Participate in classes on treatment of psychiatric disorders for hospital staff.

9. Maintain a professional relationship at all times with staff and patients, and recognize and follow the chain of command.

10. Record nursing notes daily on each patient.

11. Document patient behavior, affect, signs, and symptoms. Report changes in behavior to the psychiatric nurse.

12. Be on call to Casualty Receiving Area to assist in psychiatric admissions, if notified by Head, Neuropsychiatry Department or psychiatric nurse.

13. When work is completed, report to LPO NP Tech for further assignment.

14. Pass word to oncoming watch.

QUALIFICATIONS:

1. Petty Officer (C-4 or above).

2. Completion of Neuropsychiatric Technician School, and has NEC 8485.

3. Previous experience in psychiatric care is desired.

4. Basic Cardiac Life Support (BCLS) certification.

5. Level II certification IAW NAVMEDCOMINST 6550.3 to initiate and monitor parenteral IV fluids.

6. Medication certification.

7. Restraint application certification.

8. Possess knowledge of hospital policies and procedures as well as military

regulations, procedures, and protocols.

TAB F

REFERENCES

NUMBER	REFERENCE NUMBER	TITLE
F-1	NAVMED P5066-A	Navy Nursing Procedures Manual.
F-2		Diagnostic and Statistical Manual of the American Psychiatric Association.

TAB G

FORMS

INDEX